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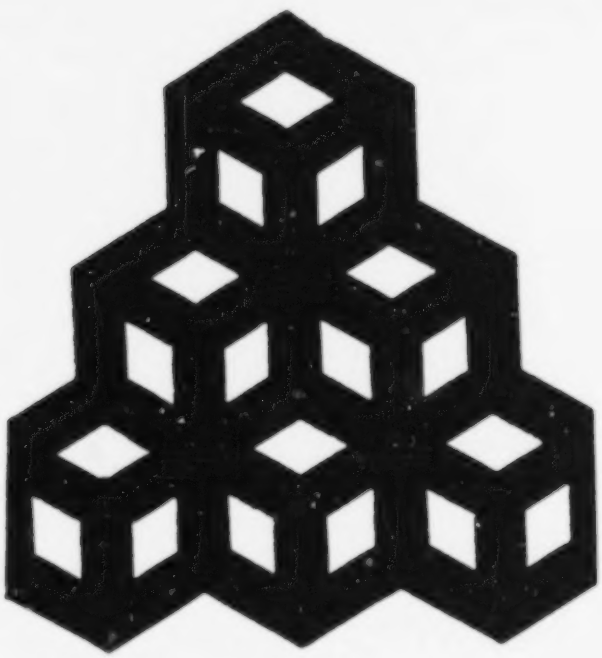
AN OVERVIEW OF FINANCIAL MANAGEMENT IN BCHS FUNDED PROJECTS



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Services Administration
Bureau of Community Health Services

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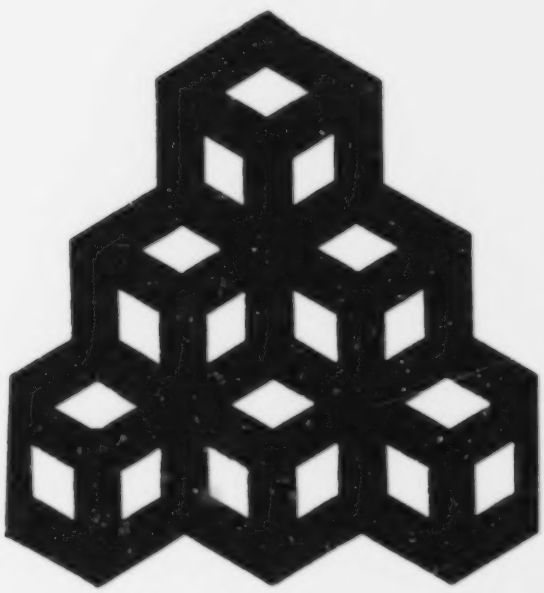

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
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5600 Fishers Lane
Rockville, Md. 20857

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INTRODUCTION

Financial management encompasses the activities related to controlling the financial resources of an organization. Financial management involves numerous functions ranging from initial planning to final evaluation of the organization's activities. This manual is an overview of the financial management process for ambulatory health care centers. The major responsibilities of a financial system, including planning and budgeting, setting fees, billing and collections, managing accounts receivable, monitoring the financial status of the center, maintaining internal controls, and securing the annual audit are discussed.

The primary purpose of any ambulatory health center is to provide quality health care to patients. In order to accomplish that purpose, a center must remain financially viable. Of the many functions the governing board and project director perform, none is more important than to ensure that the center has the financial means for fulfilling its objective to provide quality health care.

The governing board is ultimately responsible for the financial disposition of the health center. The board establishes financial policies and monitors the effectiveness of those policies through the review of monthly financial reports, the Bureau's Common Reporting Requirements (BCRR) reports, and the annual audit and accompanying management letter. The project director and the Bureau of Community Health Services (BCHS) regional project officer share the board's financial responsibility. The project director administers the board's policies by establishing and monitoring financial procedures and controls on a day-to-day basis. The regional project officer monitors the financial status of the center by reviewing copies of the financial policies and procedures, by receiving periodic financial reports to review, and by working with project board and staff members to find remedies for financial problems.

This manual provides an overview of the important functional areas of financial management. Its purpose is to assist primarily regional office staff. However, governing boards, project directors, and fiscal staff may also benefit from this guide. While information contained in this guide may also be useful to regional grants management staff, the primary goals of this document are to provide the project officer with meaningful concepts in financial management and to establish responsibility for the implementation of these policies and procedures. The manual has been designed for those new project officers with little or no formal training or for those who wish to update their skills in the field of financial management.

The Bureau of Community Health Services has other materials that are helpful in understanding the financial management process. The Annotated Bibliography at the end of this manual provides a list of those materials. The Appendix contains a checklist that can be used to evaluate each of the four components of the management cycle in a health care center. Other evaluative tools to assist regional project officers and project staff are available, including the Project Officer's Site Review Checklist, 1977 and

the Primary Care Effectiveness Program Review Manual, 1980. While the above two documents are directed primarily to regional project officers, they may also be used by project staff to assess center performance and identify its strengths and weaknesses.

This manual is divided into the four sections listed below.

- I - Planning and Budgeting
- II - Fiscal Operations
- III - Accounting
- IV - Financial Analysis

As depicted in Exhibit 1, the four sections form a management cycle, beginning with Planning and Budgeting and ending with the Analysis of Financial Data. The feedback arrow indicates that the cycle is continuous in that analysis of current financial data helps determine future planning and budgeting needs.

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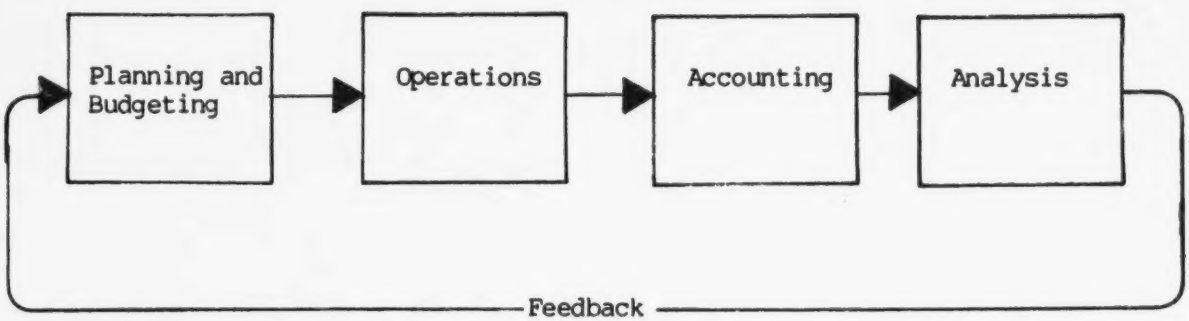
EXHIBIT 1

FINANCIAL MANAGEMENT CYCLE



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SECTION I

PLANNING AND BUDGETING

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PLANNING AND BUDGETING

The planning and budgeting functions represent the initial steps in the financial management cycle. Planning and budgeting cannot be separated, for the budget is a quantitative description of program plans. Many managers believe the budget is a control technique, but it is a planning tool as well because it provides a basis for action. Exhibit 2 shows the relationship between the planning process and the budgeting process. Proper completion of these two steps provides the framework for developing a systematic method for making decisions and controlling the financial management process.

THE PLANNING PROCESS

Planning can be described as a process of thinking ahead, anticipating and preparing for future activities. If planning takes a back seat in day-to-day problem solving, center operations can lack direction; thus unforeseen and unpredictable problems may result. Each BCHS project is required to demonstrate the results of its planning process in the annual grant application by describing goals and objectives for the coming year and progress in meeting past goals and objectives.

Program Planning

Planning is sometimes divided into two types -- short range planning and long range planning. Short range plans involve the activities that will take place over the next month, quarter, or year. Long range plans pertain to those activities that will take place over a longer period of time, usually three to five years. Short range and long range plans should be compatible and consistent. The steps in developing both short and long range plans are to:

- ensure common understanding of the program objectives;
- identify alternative plans of accomplishing the objectives;
- evaluate the alternatives and select the most appropriate plan;
- develop the plan; and
- implement the program.

Program planning is a continuous process of selecting short range and long range goals, formulating plans for attaining those goals, investigating reasons for deviation from those goals, and resetting goals.

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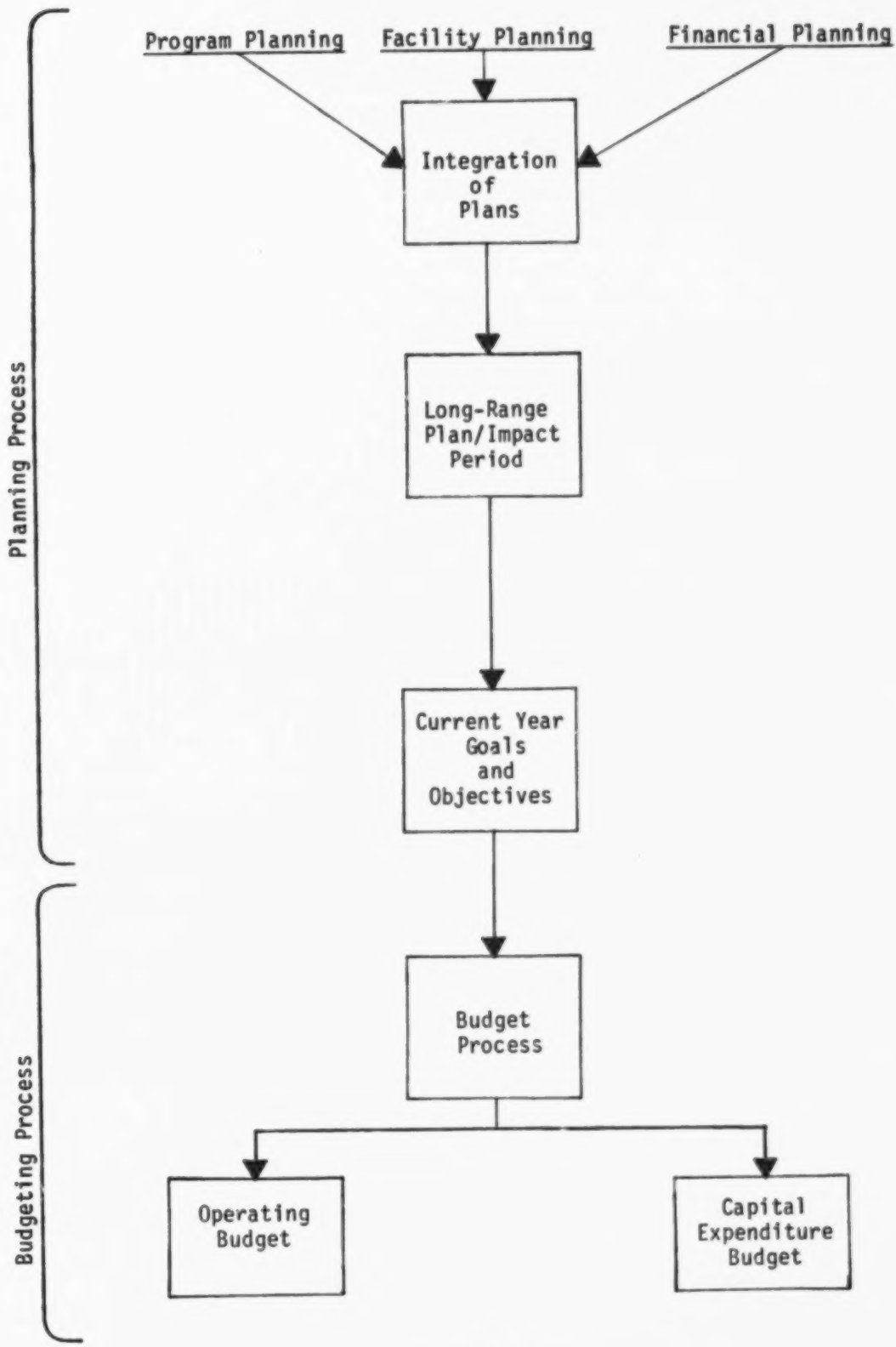
EXHIBIT 2

RELATIONSHIPS BETWEEN PLANNING AND BUDGETING



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Facility Planning

After decisions are made concerning the short and long range program plans, the center must determine if adequate space exists for the services to be provided. Facility planners must be cognizant of federal building requirements. BCHS has published Facility Planning Guidelines for Ambulatory Health Centers as a general guide for the planning and development of an ambulatory health center. Space Guidelines for Ambulatory Health Centers and Equipment Guidelines for Ambulatory Health Centers are also available from the Bureau, and are aids in designing space and equipping a health center.

Through an agreement between the Department of Health and Human Services and the Department of Agriculture, Farmers Home Administration loans may be available to community and migrant health centers in medically underserved rural communities. The low interest loans have a maximum repayment period of 40 years. A center applying for a loan under this program must have a reasonable plan for repaying the loan over time.

THE BUDGETING PROCESS

A budget is a formal quantitative expression of plans. Once the center determines the activities it wishes to undertake for the coming year(s), the budget can be prepared to translate those goals, objectives, and plans into revenue and expense figures. The project director normally takes the lead role in developing the budget. Input should be obtained from others, such as the medical and dental directors and department heads and supervisors in determining individual department needs. The governing board's finance committee should review and approve both the operating and the capital expense budgets. Once approved, they should then be submitted to the full board for review and approval.

Budgets must be completed each year and accompany the initial and continuation grant application for BCHS evaluation and approval. The following section discusses the two types of budgets required -- the operating budget and the capital budget.

Operating Budget

The operating budget consists of the statistical budget, the revenue budget, and the expense budget. The statistical budget is an estimation of the number of encounters expected from each of the center's programs, such as medical, dental, and other health encounters. After the first year of operation, the statistical budget can be estimated quite accurately by using the previous year's encounters and adjusting for an expected rate of growth or change in program status.

The revenue budget includes expected revenue, adjustments to that revenue, and receipts the center expects to ultimately collect. Revenue includes:

- grants from federal, state, and local governments;
- fee income from third parties and patients for services rendered;

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- donations;
- income from space rental and sale of equipment; and
- other miscellaneous income, if applicable.

The revenue generated by providing services will not neccessarily be realized. Contractual allowances, patient discounts, and bad debt expense will reduce the amount ultimately collected. Unless care is taken when preparing the statistical budget and the revenue budget, the center might not realize its expected receipts for the period. The amount of receipts depends on:

- the number of encounters;
- the average charge per encounter; and
- the percentage of charges collected.

An error in any one of the three factors can result in overestimating or underestimating revenue or receipts. For example, a center may budget 5,000 encounters at an average expected charge of $20.00 per encounter and anticipate a collection rate of 80 percent. The center may actually experience only 4,000 encounters with an average of $21.00 and a collection rate of 71.5 percent. In this example, encounters were overestimated by 1,000 encounters, the average charge was underestimated by one dollar per encounter, and the collection rate was overestimated by 8.5 percent. Table 1 shows that the center has overestimated receipts by $19,940. The center will collect $19,940 less during the year than expected. A discrepancy of this type can occur when care is not taken in determining realistic

TABLE 1: Example of Budgeted vs. Actual Collections

	ENCOUNTERS		AVERAGE CHARGE PER ENCOUNTER		NET BILLING		COLLECTION RATE		COLLECTIONS
BUDGETED	5,000	x	$20	=	$100,000	x	80.0%	=	$80,000
ACTUAL	4,000	x	$21	=	$ 84,000	x	71.5%	=	$60,060
							DIFFERENCE		$19,940

estimates. Each completed year of operation provides additional data for the center's historical data base from which more reliable revenue forecasts can be generated.

The expense budget contains all expenses other than capital expenditures. It includes salaries and fringe benefits, and other operating expenses such as rent, utilities, consultant fees, administrative and medical supplies, depreciation, and staff training expenses. Projects which have National Health Service Corps personnel are also required to include the NHSC repayment in their budgets. Most of the guesswork with regard to expenses occurs in the first year when some amounts must be estimated. As with the revenue budget,

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these items become easier to budget in subsequent years with the existence of historical data.

Capital Budget

The capital budget process involves budgeting for buildings and fixed equipment — those items having a useful life of over one year and a high dollar amount per item. A capital budget should show the sources of funds which are to be used for capital expenditures. The Bureau of Community Health Services' Accounting Manual states that an item must be capitalized if it costs over $300 and has a useful life of over one year. A center may have a lower dollar amount capitalization criterion and many centers capitalize any item costing over $50 or $100; but a center cannot have higher dollar amount capitalization criterion. Vendors can be contacted to determine the price of a piece of equipment if there is a question of whether it should be considered a capital expenditure. The capital budget is also approved by the governing board.

A capital expenditure schedule should be prepared which shows, month by month, the planned expenditures for buildings and equipment. The schedule may be revised monthly or quarterly as construction schedules or purchasing priorities change. Table 2 is an example of an annual capital expenditure schedule which shows, by month and item, the anticipated expenditures of buildings and fixed equipment for the year.

TABLE 2: Capital Expenditure Schedule

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
RENOVATION	7,000											
MICROSCOPE						2,000						
CENTRIFUGE						1,500						
TYPEWRITER, ELECTRIC										1,200		
TABLE, EXAMINING		3,000										
DESK		300										
TOTAL	7,000	3,300				3,500				1,200		

Budget Revisions

If the budget is tied to realistic goals and objectives, it should need little, if any, revision. However, goals and objectives sometimes change. New goals are initiated; old goals are dropped or modified for a variety of reasons — there may be a new initiative by a funding agency, an outside lab may offer adequate service at less cost than is being incurred currently by the center's in-house lab, or equipment might need to be replaced sooner than expected. The budget should be modified to reflect conditions which have developed since its original preparation.

A change in the budget must be submitted to the regional office for approval after it has been approved by the center's governing board. Some examples of a need to revise the budget are major changes in the following:

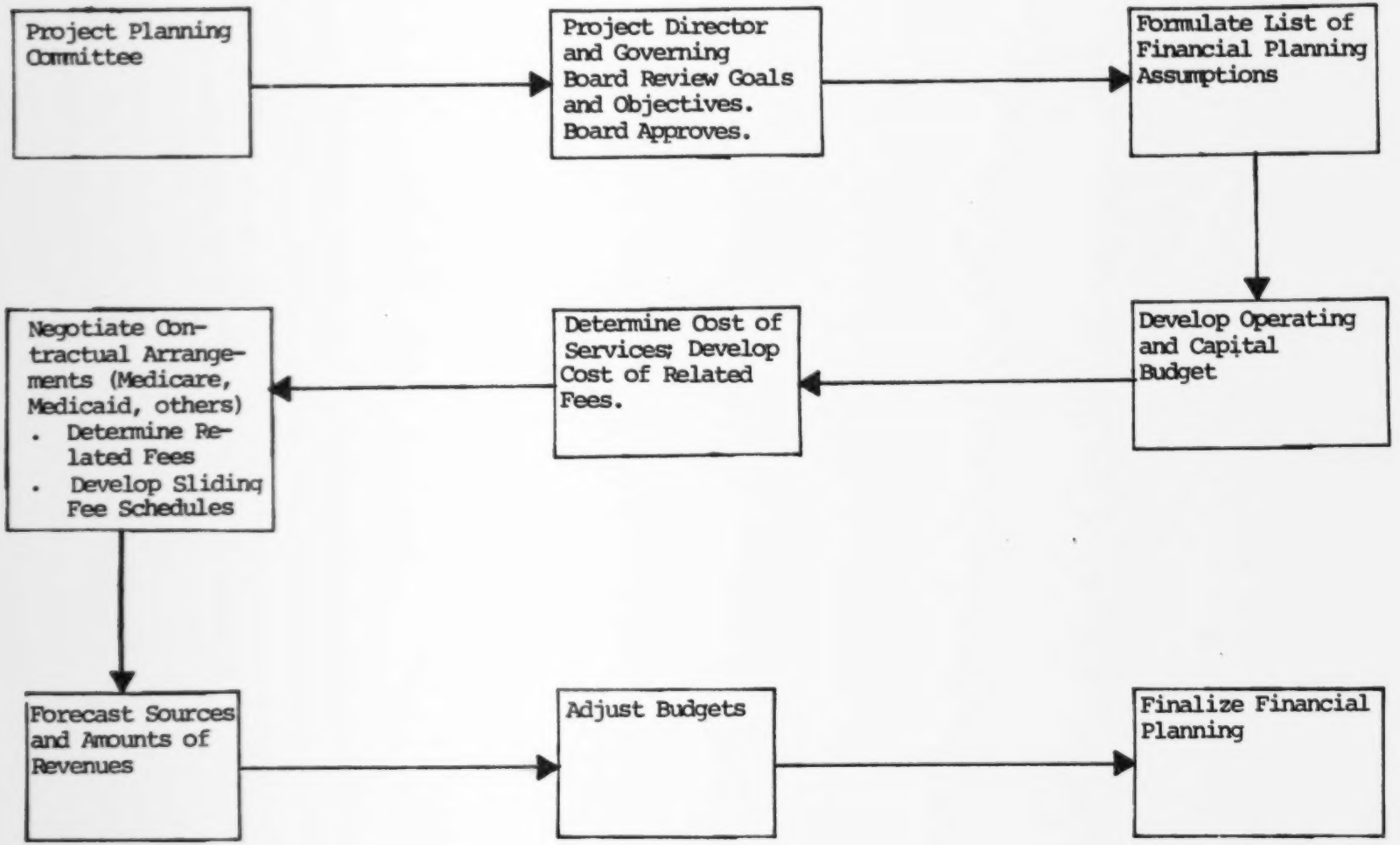
- funding level or other sources of revenue;

- programs or activities;
- ongoing expense items, such as increased cost of contractual services or insurance; and
- staffing.

The planning and budgeting process is depicted in Exhibit 3. Developing a discount fee schedule and negotiating contractual agreements are two functions shown in the exhibit which must be performed prior to completing the revenue budget. These functions are discussed in the next section of this manual.

EXHIBIT 3

THE FINANCIAL PLANNING & BUDGETING PROCESS


Project Planning Committee
Project Director and Governing Board Review Goals and Objectives. Board Approves.
Formulate List of Financial Planning Assumptions
Develop Operating and Capital Budget
Determine Cost of Services; Develop Cost of Related Fees.
Negotiate Contractual Arrangements (Medicare, Medicaid, others)
. Determine Related Fees
. Develop Sliding Fee Schedules
Forecast Sources and Amounts of Revenues
Adjust Budgets
Finalize Financial Planning

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SECTION II

FISCAL OPERATIONS

SECTION II
FISCAL OPERATIONS

This section discusses the components that make up the fiscal operations of an organization. After planning and budgeting are completed, financial systems must be developed and put into place. Fiscal operations involve implementing and monitoring those systems that are needed to assure sound financial operations. The following operations are discussed below:

- fee schedules;
- billing and collections;
- accounts receivable;
- purchasing and inventory control; and
- accounts payable.

FEE SCHEDULES

A fee schedule is an important aspect of any community-based health center. By regulation, a center must maintain a schedule of fees designed to recover its reasonable cost of operation and a corresponding schedule of discounts adjusted on the basis of the patient's ability to pay. The project director is responsible for establishing the fee schedule, which should be carefully reconciled to the population served. The fee schedule must then be approved by the governing board. It may be reviewed by the board's finance committee prior to submission to the full board.

The first consideration in developing a fee schedule must be whether to use an all-inclusive clinic rate or a fee-for-service charge structure. An all-inclusive, or clinic rate, requires taking the budget forecast of costs and anticipated encounters and determining a cost per encounter by dividing the total costs by the total number of anticipated encounters. This is a simple charge structure where all patients are charged the same, regardless of the type or amount of services they receive during an encounter.

Traditionally, health centers have found that fee-for-service represents the more practical choice of the two methods of pricing services. It is more equitable for patients to be charged varying amounts depending on the service they receive; however, it is more difficult to initiate the fee-for-service charge structure since charges must be developed for each service offered, such as office visits, lab tests, and x-ray exams. BCHS has published Guidelines and Procedures for Cost Finding, Charge Determination and Developing a Sliding Fee Schedule in Ambulatory Health Centers which describes the steps and procedures involved in developing a fee schedule. This manual presents an approach to setting fees at a level that will cover the cost of operations. The manual uses a six-step process to:

- determine the total unit cost of each service provided by

the center;

- develop a method to use the cost per service information to set charges that will cover costs; and

- develop a method to adjust charges according to a patient's ability to pay.

In addition to determining health center costs for individual services, the project director should consider other guidelines, as listed below, before finalizing the fee schedule.

- What are the regional fee schedule profiles established by major third party payors, such as Medicare?

- What are the fees of other providers within the area who are providing the same or similar services?

- What is the impact of setting fees too high or too low? Will the fee schedule alter the profile of the region and center?

Consideration of these guidelines will ensure that the center will not drastically undercut the customary fees of other providers. Third party carriers can be contacted directly for regional profile information. The profiles are based on an accumulation of claims data and are consistent with the usual, customary, and reasonable charges of the area. Governing board members and center providers can often be of assistance in obtaining charge information from other providers in the community.

If center rates exceed prevailing area rates, the center may find itself relatively non-competitive to other service providers in the area. This will necessitate reexamination of the center's rates and costs in an effort to bring its charges in line with the prevailing area rates. There may be a need to put more effort into cost containment techniques such as:

- examining the center's goals and objectives to determine if any programs can be reduced or eliminated without seriously affecting the quality of patient care;

- examining the budget to determine if costs can be reduced or eliminated; and

- determining if the center is operating at capacity; and as necessary, make appropriate adjustments.

If costs and programs cannot be reduced enough to bring fees in line with prevailing area rates, the only alternative is to use grant funds, if available, to underwrite the deficit.

Given these considerations, a workable fee schedule can be developed around the practice specialty, the community's ability to pay, and the projected cost of operation. A typical fee schedule will have fees developed for the following areas:

- office visits;
- house calls;
- hospital visits;
- procedures and treatments;
- laboratory;
- x-ray; and
- supplies (including pharmaceuticals).

Once the fee schedule is developed, procedures should be written defining its use. Normally, providers indicate on the encounter form which services were provided, and the cashier determines the appropriate charge based on the service(s) rendered. Application of any discount schedule should be performed based on the total charges for the visit.

Discount Schedule

BCHS funded projects are located in medically underserved areas and emphasize access to care by low income as well as middle and high income individuals and families. Federal regulations require that health centers have a schedule of fees designed to cover reasonable costs of operations and a corresponding schedule of discounts (which results in the commonly referred to "sliding fee scale") adjusted on the basis of the patient's ability to pay. The regulations state that individuals or families with an annual income at or below the most recent Community Services Administration (CSA) poverty income guidelines should receive a full discount, except for the possible assignment of a nominal fee. Individuals or families with annual incomes greater than twice the poverty guidelines should receive no discount.

For persons who fall between those two extremes, most centers use a graduated discount schedule similar to the one shown in Exhibit 4. The schedule shows that, according to family size, patients are charged 20 percent of total charges if their annual income is 20 percent above the poverty level; and so on, until a patient pays full charges if his/her family income is twice the poverty level. In this example, the nominal fee is $3.50. Each center is encouraged to set its own nominal fee at a level consistent with project goals.

Community Services Administration poverty income guidelines are adjusted upward each year around April or May to account for inflation. These guidelines are published in the Federal Register. Centers should contact the BCHS regional office for a copy of the guidelines if they have difficulty obtaining copies elsewhere.

BILLING AND COLLECTIONS

Billing and collections encompass two separate areas: direct patient billing and third party billing. The billing and collections process starts with the patient registration and encounter process. During the patient registration process, the center determines the patient's eligibility for

EXHIBIT 4*

SLIDING FEE SCALE: PERCENTAGE OF MAXIMUM CHARGE
BASED ON FAMILY INCOME AND SIZE (FOR NON-FARM FAMILY)

Family Size**	0%***	20%	40%	60%	80%	100%
1	0 - 3790	3791 - 4739	4740 - 5688	5689 - 6637	6638 - 7580	7580
2	0 - 5010	5011 - 6264	6265 - 7518	7519 - 8772	8773 -10020	10020
3	0 - 6230	6231 - 7789	7790 - 9348	9349 -10907	10908 -12460	12460
4	0 - 7450	7451 - 9314	9315 -11178	11179 -13042	13043 -14900	14900
5	0 - 8670	8671 -10839	10840 -13008	13009 -15177	15178 -17340	17340
6	0 - 9890	9891 -12364	12365 -14838	14839 -17312	17313 -19780	19780
7	0 - 11110	11111 -13889	13890 -16668	16669 -19447	19448 -22220	22220
8	0 - 12330	12331 -15414	15415 -18498	18499 -21582	21583 -24660	24660
9	0 - 13550	13551 -16939	16940 -20328	20329 -23717	23718 -27100	27100
10	0 - 14770	14771 -18464	18465 -22158	22159 -25852	25853 -29540	29540

* Based on CSA Income Poverty Guidelines published April 21, 1980
Source: Federal Register, Vol. 45, No. 78.

** For family units with more than 10 members, add $1,220 for each additional member in a non-farm family.

*** Nominal fee charge of $3.50 for zero pay patients.

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services and identifies the source of payment, which is essential for accurate and complete billing and collection. The data collected helps the center advise the patient on eligibility for other programs if it appears that he/she has no insurance coverage and cannot pay for services. When possible, an office or cubicle should be provided to offer some privacy in obtaining registration information. Each time the patient receives health care services at the center, a staff member should verify that the registration information is current. This process ensures that time and money are not spent sending statements to incorrect addresses.

In the ideal situation in which all charges are collected during the patient visit, no billing and collection effort is necessary. A billing and collection system is necessary for those patients who do not immediately pay the full charge of a visit and for those patients who wish the center to bill an insurance carrier or other third party.

The regulations governing federally-funded health programs require collection of charges for services rendered to patients. There must be a board-approved billing and collection policy including provision for patient confidentiality. Furthermore, there should be provisions for policies governing collection from self-pay patients in accordance with the center's fee schedule and corresponding schedule of discounts. The purpose of this section is to define a billing and collection system which will allow health centers to bill self-pay patients and third parties easily and efficiently and to follow up with those who do not pay promptly.

Self-Pay Billing

A self-pay patient is one who has no third party coverage; or has third party coverage for which the center does not accept assignment. Payment is expected from self-pay patients at the time services are delivered. Collecting at this time reduces potential billing expense and the possibility of incurring bad debt expenses. Credit should be extended only to those patients who request and need it. If credit is extended and the patient qualifies for a discount, the appropriate adjustment should be made prior to billing.

Assignment refers to the transfer of insurance benefits from the patient to the center. Centers must accept assignment for patients eligible for Medicare, Medicaid, and for Title XX social services and family planning services. The governing board of each health center must decide if the center is going to accept assignment from patients with private insurance coverage.

Third Party Billing

A significant portion of the health center's revenue is often generated through third party reimbursements. During the registration process those patients without insurance coverage should be identified. Every effort should be made to assist those eligible for third party benefits to obtain such coverage. In order to minimize unnecessary claims processing, the patient's coverage status should be verified during each visit.

The cost-based rate schedule, adjusted to prevailing area rates, is the basis on which third parties should be billed. The major question to consider

in processing claims is: Are the bills submitted promptly and accurately? If the payor's criteria for all other factors have been met and bills are submitted promptly and accurately, a center would be entitled to full reimbursement according to the established rate. Persistence may be required to follow up on claims that are returned unpaid or paid at less than the amount expected. When a claim is denied, the account is changed to self-pay status, the patient notified, and the self-pay billing process initiated. The reason for a denied claim should be determined to prevent any such future denials.

If a center does not bill all possible claims as efficiently as possible, reimbursements may not be maximized because:

- claims are lost, and so, revenue is lost;
- incorrect amounts are billed; or
- the cost of billing offsets the total amount collected.

Since reimbursement of claims varies considerably among carriers, establishment of an ongoing dialogue with all the third party payors covering the center's patients can prove helpful in understanding the claims filing process, and thus, avoiding delays. Medicare, for example, reimburses at the rate of 80 percent of reasonable charges after an annual deductible is met by the patient. Each state determines its own eligibility, services covered, and rates of reimbursement for Medicaid patients. Reimbursement for physician assistants, nurse practitioners, and other mid-level providers also varies from state to state.

Private medical policies vary tremendously among insurance companies. Some policies cover laboratory and x-ray costs, as well as physician charges, while others do not. Often patients do not know the details of their coverage. A telephone call placed to the patient's employer or insurance carrier can resolve any uncertainties and save unnecessary filing of claims. Insurance companies will often train center personnel to complete the required reimbursement forms and instruct them on the information required to justify claims for approval.

Collection Policies

The claims follow-up process is as important as the billing process. A written credit and collection policy known by all center board members and employees serves to:

- ensure that all patients are given the same orientation to the credit policy and that no patient will mistake the position of an individual staff member as the position of the health center; and
- assist in maximizing collection.

Inherent within a sound collection methodology is a policy decision that the receivables are to be collected, as well as a firm outline of the parameters that are to encompass the collection procedures. Follow-up

procedures including frequency, number of notices, and wording of the notices must be predetermined. Once the policy has been set, it must be adhered to vigorously. Those involved in the collection effort must have access to complete patient financial records, including a copy of the patient's payment record to ensure efficiency. If a patient cannot be located during the collection process, the chart should be flagged to update the patient's address during the next visit. The inability to locate a patient can result from incorrect information obtained during registration or from the patient's moving without leaving a forwarding address.

ACCOUNTS RECEIVABLE

Accounts receivable is the total amount due from patients and third party payors. It represents services that have been provided to patients for which the center has yet to be reimbursed. Accounts receivable may be maintained on a pegboard or one-write system and updated daily.

Most insurance companies pay a claim within a month or two following submission of that claim by the health center. Medicare and Medicaid may require more time to reimburse. Self-pay patients are normally expected to pay for services at the time they are delivered unless other arrangements are made. Negotiations with the patient might result in an agreement for payment within thirty days or for a series of payments over several weeks or months. If an account payment has not been received for the specified period of time outlined in the billing and collection policy, the account is declared uncollectible and should be written off to bad debts.

Some centers turn bad debts over to a lawyer or collection agency; others do not. This is an individual center decision which must be approved by the governing board. Collection agencies normally charge the center between one-third and one-half of the amount they collect. Whether an account is turned over for collection or not, an attempt should be made to collect the outstanding debt should the patient return to the center for additional services.

There are various performance indicators that can be used to monitor accounts receivable. These indicators assist project staff in making decisions and in monitoring the center's progress toward achieving financial viability. Aging the accounts and determining the collection period are two common methods for evaluating the accounts receivable.

Aging Accounts Receivable

Aging the outstanding accounts consists of classifying individual patient balances according to the period of time the account has remained unpaid. The older the claim, the less likely it is to be collected. This procedure gives project staff an idea as to the extent the accounts receivable are collectible. A format for aging accounts receivable is shown in Table 3 which follows.

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Table 3: Aging of Accounts Receivable

(1)	(2)	(3)	(4)
Age of Accounts	Amount	Estimated Percentage Uncollectable	Estimated Amount Uncollectable (2) X (3)
0-30 days	20,000	5	1,000
31-60 days	15,000	15	2,250
61-90 days	10,000	35	3,500
Over 90 days	5,000	80	4,000
TOTAL	$50,000		$10,750

The aging process in this case shows that $10,750 of the $50,000 will probably end up as uncollectible and be written off as a bad debt expense. The percentage figures in Column 3 are based on past collection experience. The aging of receivables is useful for planning and budgeting purposes. If it appears that the uncollectible amount is going to be greater than expected (budgeted), the potential for a cash shortage exists, requiring that corrective measures be taken, such as reducing future expenditures or devising a plan to increase collections.

Average Collection Period of Receivables

A second accounts receivable management tool is the average collection period of receivables -- the number of days' revenue in accounts receivable. For example, assume that the health center represented by Table 3 averages $50,000 in accounts receivable and has average daily charges of $800. The formula reads:

$$\frac{\text{Average Accounts Receivable}}{\text{Average Daily Net Charges}} = \frac{\$50,000}{800} = 62.5$$

This hypothetical health center has 62.5 days of charges tied up in accounts receivable. A long collection period indicates either that the center is using a liberal credit policy or that the receivables are of low quality with many patients or third parties failing to pay their bills on time. It may also indicate that revenue is being recorded but not billed, or not billed promptly.

Determining the collection period will, over a period of time, show a trend in receivables which can be used in making fiscal management decisions. For example, a number of measures might be taken if the trend shows that the collection period is increasing. These measures may include examining the

billing and collection procedures to ensure staff compliance, ensuring that the cashier is maximizing collections when services are rendered, tightening the requirement for extending credit to patients, or using a collection agency for delinquent accounts over 90 days in arrears.

PURCHASING AND INVENTORY CONTROL

Purchasing and inventory control are also components of fiscal operations. Effective purchasing and inventory systems help to ensure that only those needed and budgeted items are ordered and that they are accounted for periodically to prevent loss due to fraud or negligence. BCHS has published Procurement Guidelines for Community Health Centers to assist project staff in developing a purchasing and inventory control system.

Purchasing

The purchasing function includes all of the decisions, policies, and activities involved in procuring goods and services from outside the center. Generally, the project director is responsible for approving all purchase requisitions and signing all purchase orders. The purchasing policy should identify any other staff members who are allowed to authorize purchases and under what circumstances they are permitted to do so.

A purchase requisition is an internal document used by a department head or supervisor to request the purchase of an item. If the project director feels that the requested item is needed and that provisions have been made for it in the budget, then he/she may approve the requisition for purchase.

A purchase order is completed and forwarded to the vendor for purchase of all materials and services, except for those purchased with petty cash. The purchase order may be prenumbered and in four copies; one for the numerical file for control purposes, one for the vendor file, one for the accountant or bookkeeper, and the original copy to be sent to the supplier or vendor. When the item arrives, the packing slip is checked against the purchase order to ensure that the correct item(s) has been received. Full payment should not be made to the vendor until all items have been received, examined, and found to be satisfactory. Exhibit 5 shows a typical flow of the purchasing process.

Choosing vendors is an important aspect of purchasing. Only reputable and dependable vendors should be considered. Substantial savings can often be realized by securing bids or quotations on all high cost items and high volume-low cost items. The lowest bid is not always the best bid for equipment or supplies. Provider satisfaction, delivery time, maintenance agreements, and the convenience of the vendor are other factors to consider. This is particularly true with the purchase of pharmaceuticals where physician/dentist approval and patient response to medication are important factors to consider. The right price for any item(s) purchased is the lowest price obtainable for a quality product from a dependable supplier in a reasonable quantity. A reasonable quantity must be based on availability, storage space, obsolescence, and quantities used. Perishable supplies should be rotated as new stock arrives.

Health centers in some regions have been very successful in forming cooperative purchasing agreements and bulk ordering. Ordering in greater

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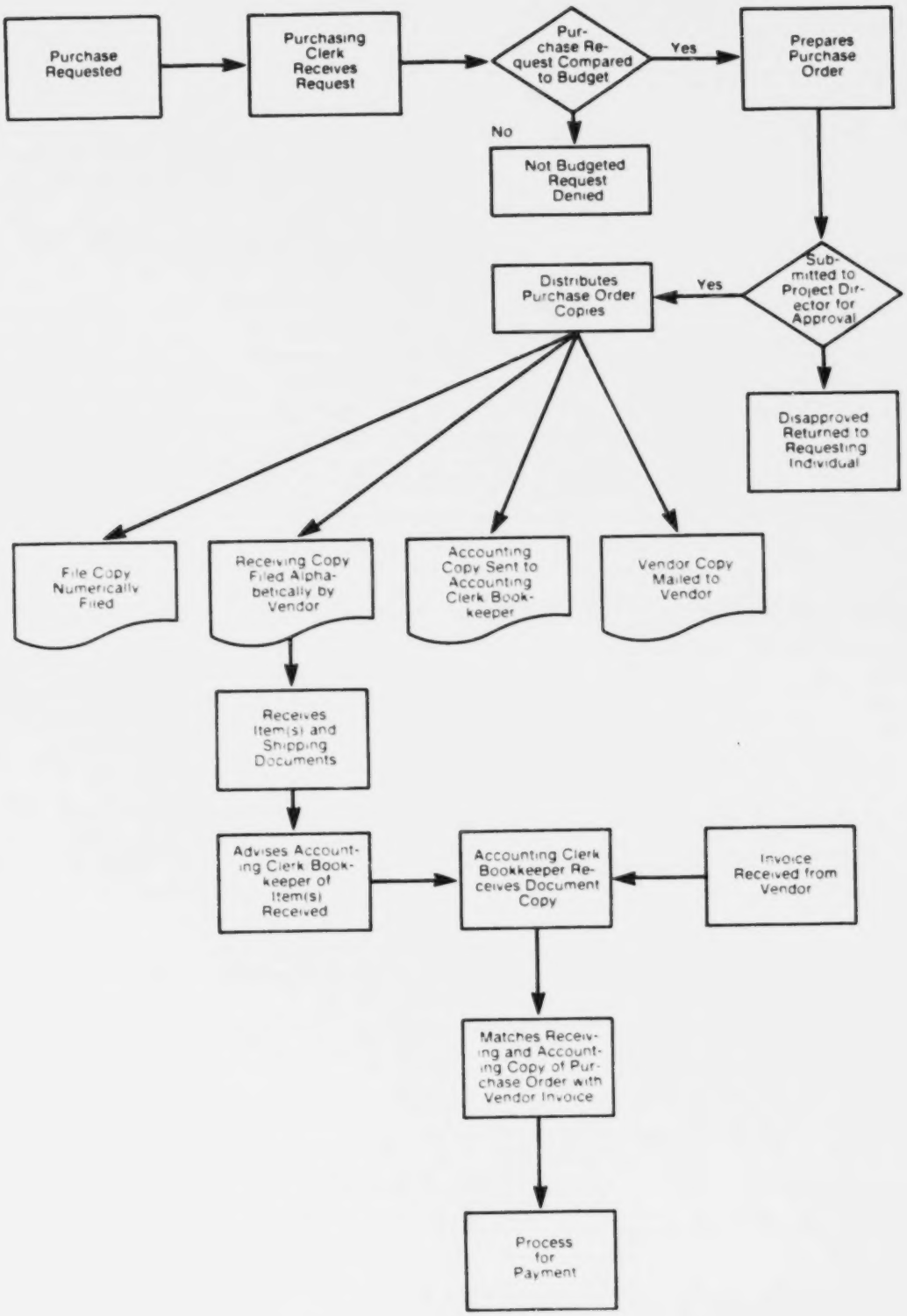
EXHIBIT 5

PURCHASING FLOW CHART EXAMPLE


Purchase Requested
Purchasing Clerk Receives Request
Purchase Request Compared to Budget
Yes
Prepares Purchase Order
No
Not Budgeted Request Denied
Submitted to Project Director for Approval
Yes
Distributes Purchase Order Copies
Disapproved Returned to Requesting Individual
File Copy Numerically Filed
Receiving Copy Filed Alphabetically by Vendor
Accounting Copy Sent to Accounting Clerk Bookkeeper
Vendor Copy Mailed to Vendor
Receives Item(s) and Shipping Documents
Advises Accounting Clerk Bookkeeper of Item(s) Received
Accounting Clerk Bookkeeper Receives Document Copy
Invoice Received from Vendor
Matches Receiving and Accounting Copy of Purchase Order with Vendor Invoice
Process for Payment

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quantities, especially such things as supplies and pharmaceuticals, can substantially reduce the cost per item.

Inventory Control

Inventory control can be divided into two sections: expendable items and property and equipment. Expendable items are those items such as medical and office supplies, which are consumed within a short period of time. Some centers choose to expense supplies as they arrive rather than as they are consumed. Expensing supplies initially simplifies the bookkeeping process but sacrifices control of the supplies since no record is maintained with the amount and value of supplies on hand.

If a center wishes to maintain more control over its supplies and expense items as they are consumed, it must conduct inventories to determine the related consumption rates and the points at which the supplies must be reordered. There are two types of inventory control systems: perpetual and periodic. The perpetual inventory system provides the most control over the stock and aids in the prevention of overstocking items or having to place emergency orders. Centers that utilize a perpetual inventory system maintain a record of all incoming and outgoing supplies which provides a constant record of supplies on hand. Centers that utilize a periodic inventory system do not maintain a constant record of supplies on hand, but conduct periodic counts. Both perpetual and periodic inventory systems require a physical count or confirmation of supplies on hand at the end of an accounting period so that the value of the supplies can be included in the appropriate financial statements.

Regardless of the method of treating supplies, all centers should inventory both center owned and leased capital equipment and non-consumable items which have a useful life of over one year and cost over a previously determined dollar amount, such as $25, $50, or $100. Non-consumable items are such items as calculators, desk lamps, and chairs. Equipment records can be created for each item over the decided upon value. An equipment record should contain:

- item description;
- identification number (if used);
- date purchased;
- cost;
- estimated useful life; and
- location.

A physical inventory of the equipment conducted at least once a year will:

- verify the existence of the property;
- determine utilization status of the property (in use or in storage); and

- permit a check on its condition to determine if and when retirement/replacement will be required.

Missing items should be reported to the insurance carrier for reimbursement, if such coverage is maintained.

ACCOUNTS PAYABLE

Accounts payable are those amounts owed to others, such as to vendors for goods and services, to employees for work performed, and to the Internal Revenue Service for accrued payroll taxes. If all obligations were paid at the time goods and services were received, then there would be no need for an accounts payable system. Accounts payable serves to control and track liabilities which the center has incurred. This allows for more efficient batching of payments (periodically writing checks for these goods and services) to vendors. Additionally, accounts payable allows centers to exercise more efficient cash management.

Cash Disbursement Function

For a small center, checks can be written once or twice a month. Many centers write checks at the same time payroll checks are prepared. This batching method of accumulating bills and writing checks is less time consuming than writing one or two checks each day. Exceptions may be needed, however, if an invoice arrives which offers a discount for timely payment or assesses a penalty for late payment. When a disbursement is made, supporting documents should be attached to the check so future verification may be possible.

Timely deposit of payroll taxes to the Internal Revenue Service are particularly critical because penalties are assessed if payments are not made by the due date. The due date varies according to the amount of the liability. Effective January 1, 1981, if the undeposited tax (federal tax withholding and both the employer and employee portions of F.I.C.A.) is less than $500 at the end of a quarter, then the tax can either be paid with the Employer's Quarterly Federal Tax Return (Form 941) or be deposited with a federal tax deposit card by the end of the month following the quarter. If, at the end of any month within the quarter, the liability reaches $500 or more, but is less than $3,000, then it must be deposited within 15 days after the end of the month. A different set of criteria applies to larger organizations with tax liabilities greater than $3,000 per quarter. The penalty for late payment is five percent of the amount not deposited. Information on making deposits can be obtained from any Internal Revenue Service office.

SECTION III

ACCOUNTING AND INTERNAL CONTROL

SECTION III

ACCOUNTING AND INTERNAL CONTROL

This section discusses the accounting system and internal controls. The accounting system provides information that can be used by those responsible for decisions affecting the health center's future. In order to have confidence in the accounting data, there must be effective internal controls. Internal controls help ensure that the accounting data and resulting financial reports are reliable. Internal controls also point out mistakes so that they may be rectified and prevented from reoccurring.

ACCOUNTING SYSTEM

An accounting system consists of source documents, a chart of accounts, journals, ledgers, and the reports that are a result of the recording and reporting transactions that take place on a day-to-day basis. Each health center must develop an accounting system based on its own unique situation, including the size of the organization, its funding requirements, and the technical skills available. The accounting system should be set up at an early date with the help of an appropriate professional, such as a local certified public accountant (CPA), to help keep account of the fiscal affairs discussed in this section.

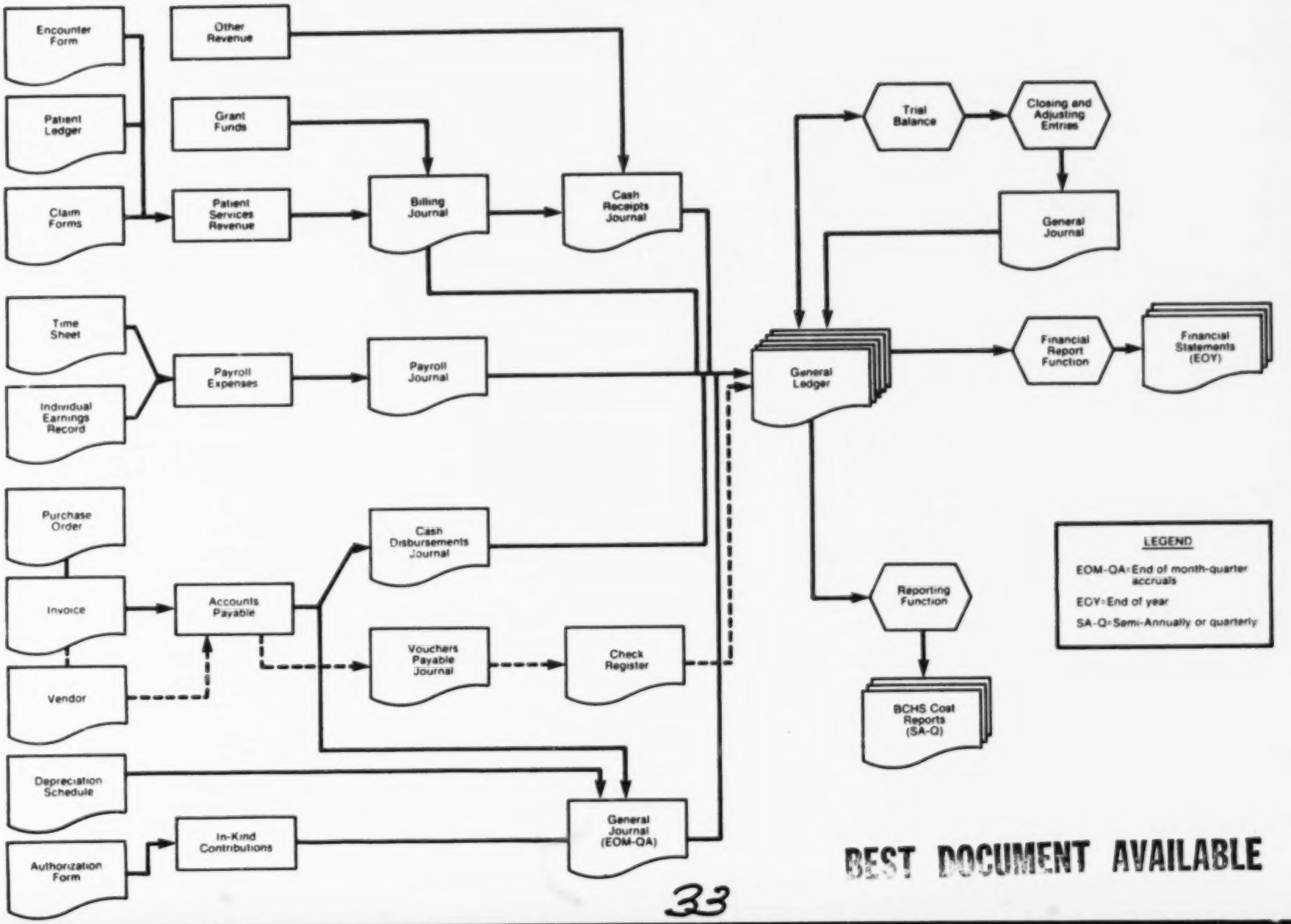
BCHS has produced several documents to assist with the accounting process. A useful document for assisting project personnel in setting up and maintaining accounting records using double entry books of account is in the Bureau of Community Health Services' Accounting Practice Set, a companion document to the Bureau of Community Health Services' Accounting Manual. Included in this set are: (1) general journal, (2) check disbursement journal, (3) cash receipts journal, (4) billing journal, (5) payroll journal, and (6) general ledger. The practice set illustrates the identification of project cost by functional cost centers, including the preparation of related cost/revenue reports of the BCHS Common Reporting Requirements (BCRR). BCHS has also developed the Illustrated One-Write Accounting Practice Set for Federally-Funded Health Centers which illustrates how a project may retain the benefits of "one-write" accounting systems (sometimes referred to as "pegboard" accounting systems) and still use double entry accounting techniques that minimize accounting errors and contribute to stronger internal controls.

Once the accounting system is in place, the center should engage a qualified accountant or bookkeeper to oversee daily operations. A CPA should be retained to review the bookkeeping work on a monthly and/or quarterly basis as well as to provide periodic financial statements. For example, the CPA may post to the general ledger and prepare monthly financial statements. This is particularly needed in a small health center which lacks accounting and bookkeeping expertise. BCHS will allow and even encourage centers who need this type of assistance to obtain it.

Exhibit 6 shows the flow of information of the financial management components through the accounting system and on to the completed monthly,

EXHIBIT 6

ACCOUNTING SYSTEM FLOW



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quarterly, or annual financial statements.

INTERNAL CONTROL

Internal control can be defined as those plans, procedures, and coordinating measures adopted to meet the need for controlling financial operations. It consists of the procedures adopted by the center to:

- safeguard its assets;
- produce accurate accounting data;
- promote efficient operations; and
- encourage adherence to prescribed managerial policies.

Effective internal controls minimize the likelihood of misappropriations of assets and maximize the likelihood of detection if misappropriations do occur. The Bureau of Community Health Services' Accounting Manual contains an excellent chapter on internal control which states that the setting up of effective controls involves:

- division of responsibility among different employees for a sequence of related functions;
- clear establishment of each employee's responsibilities and duties; and
- use of standards, proofs, checks, and other security measures.

Methods of Internal Control

A small center often cannot separate responsibilities to the extent of a large center. However, it can take basic internal control measures, such as separating the duties of authorizing purchases (project director), processing the invoice to pay for the purchase (bookkeeper), and signing the check to pay the invoice (project director and a governing board member).

Bonding employees is another way of protecting assets. Those employees handling funds or having control over any of the assets should be bonded. This includes the receptionist, cashier, bookkeeper, the secretary who receives checks in the mail, the project director, governing board members who sign checks, and others, depending on their responsibilities. If necessary, a blanket bonding policy can be obtained that covers all employees.

A further method of asset protection is obtaining adequate insurance coverage for the center. Insurance should be obtained in the areas of:

- liability for the governing board;
- malpractice for the professional staff;
- fire and extended (wind and hail) coverage;

- theft;
- flood, if in a flood plain;
- liability for bodily injury; and
- workmen's compensation.

Other protective measures include:

- bank statements reconciled by someone other than the individuals involved in the authorization, preparation, and signing of checks;
- a six-month or annual inventory taken on all fixed equipment;
- bank deposits made daily;
- pre-numbered receipts issued at the time money is received;
- limiting the use of a petty cash account; and
- rotating employees' job duties periodically.

Effective internal controls can help reduce the cost of the annual audit. Rather than reviewing every monetary transaction and counting every asset, an auditor will sample specific components of the accounting system to ensure its integrity. The more confidence the auditor has in the internal control system, the smaller the sample needs to be; thus, a reduction of auditing costs.

Internal Control Audit

Since independent auditors conduct the audit and internal control check only once a year, the project director or accountant should randomly conduct an internal control audit. An internal audit allows for discovery of unsound internal controls without waiting for the annual audit to reveal the deficiencies. The Bureau of Community Health Services' Accounting Manual also contains an extensive checklist for internal control evaluation which covers all those areas relating to sound fiscal control. The checklist is divided into 16 different areas. If only one area is examined each week for 16 weeks and needed corrections are made, the task of effective internal control can be implemented in that period of time.

After that, an internal audit schedule should be developed and followed. Some areas may need to be examined more often than others. For example, a center with a small front office staff where separation of duties or rotation of duties is not always possible, may wish to audit the cash areas monthly or quarterly while auditing all other areas semi-annually.

SECTION IV

FINANCIAL ANALYSIS

SECTION IV

FINANCIAL ANALYSIS

Sound financial analysis is important because it provides project staff with information for decision making. This section discusses three aspects of financial analysis: monitoring and evaluation, annual audit, and external reporting.

MONITORING AND EVALUATION

In health centers, management must rely to a large extent on information contained in reports developed within the organization since management may find it difficult to easily observe, analyze, and assemble all facts concerning financial management. In financial management, it is the financial reports that comprise a large portion of the reports needed by management.

The monitoring process utilizes financial reports to compare budget and actual cost figures so that management can measure how well it is achieving its plan by taking appropriate action. Management should also analyze operations using the BCRR and the Bureau's financial and administrative indicators (see BCHS Data Analysis Guide to the BCRR).

The key financial reports for on-going management decision-making are the revenue and expense reports. These reports should be based on a time interval which is long enough to allow relevant information and trends to emerge and short enough to allow effective management intervention in order to improve financial performance. Comparative reports containing prior period data are most useful tools. For most community health centers, monthly revenue and expense reports fulfill these criteria. In addition, these reports must be generated on a timely basis so that effective management decisions can be made.

Format

The format of revenue and expense reports varies with the organization and the accounting practices of the community health center. Regardless of the specific detailed format of these reports, there are certain key elements which should be present in order for these reports to be useful to management. They are:

- simplicity and clarity of reports;
- the revenue and expense reports should be in the same general format as the revenue and expense budgets;
- actual and budgeted figures and the difference between them must be displayed in close proximity so that comparison is facilitated. It is also often helpful to show the actual and budgeted year-to-date figures in order to facilitate the identification of long-term trends; and
- whenever possible, the reasons for significant differences between budgeted and actual figures should be indicated either on the report itself or by a cover letter.

Uses of Financial Reports

The main use of financial reports is to aid in decision-making. If the budget is a realistic one, then the variance of actual expenses and revenues from the budgeted figures should be explainable and controllable to a certain degree. The financial reports are the mechanisms by which such variances are brought to the attention of management. The actions taken to correct variances will depend upon the individual circumstances of each situation.

The secondary, but also important, use of the financial reports is to serve as input to short and long range organizational planning and as the historical revenue and expense data-base for the next year's budget. Organized files must be maintained for quick retrieval of historical information.

Both uses obviously require that the information presented in the financial reports be understandable, timely, and accurate. Community health centers must strive to employ a capable, well-trained financial management staff since decision-makers must have confidence in the financial reports generated. Sound financial monitoring and planning, in tandem with sound organizational planning, give all levels of management, from cost center/department heads to the governing board, a framework within which to work and the tools with which to measure performance.

ANNUAL AUDIT

Health centers which receive BCHS support must have an annual audit conducted by an independent certified public accountant or by an accountant licensed prior to December 13, 1970. The audit is performed for the use of the governing board, project staff, and BCHS. In selecting the audit firm, the project should try to select one that has experience with similar organizations. In arranging for the audit and receiving the auditor's report, the board is exercising its primary responsibility for assuring the fiscal integrity of the organization. The board and staff should use these reports to correct any weaknesses noted by auditors in these areas. Secondarily, the audit is performed to meet the requirements of outside agencies, including funding sources, agencies providing loan support, and other organizations which have a fiscal or legal interest in the center. For a detailed discussion of audits see the Bureau of Community Health Services' Accounting Manual--Chapter VII and the Public Health Services' approved audit guidelines, Guide for Audits of Financial Management and Business Systems Recipients Funded by the Public Health Service (Draft), dated January 22, 1980.

EXTERNAL REPORTING

The health center is responsible for responding to several financial reports for funding agencies. The following is a description of several of those reports which are partially or entirely financial in content.

Initial/Continuation Grant Application

Several sections of the initial or continuation grant application are

financial in nature. The annual budget, for example, must accompany the grant/continuation application each year. Thus, the operating and capital budgets must be completed prior to submission of the application to BCHS.

A narrative financial plan must also accompany the application. The financial plan should show that the revenue and expense figures are responsible cost projections in relation to the program objectives stated in the Program Plan section of the application.

BCRR Reports

The BCHS Common Reporting Requirements (BCRR) have been developed to monitor and assist in the management of federally funded health centers. This set of tables assists the Bureau to:

- report to Congress regarding the status of health center programs;
- assure compliance with legislative mandates;
- allocate resources to the regional offices;
- conduct program evaluation, including comparisons among programs, states, and regions;
- provide a data-base for objective grant awards;
- facilitate program integration; and
- identify areas where grantees need technical assistance.

In addition to the Instruction Manual for the BCHS Common Reporting Requirements, January 1980, and periodic workshops in some regional offices, the Bureau has issued other materials to assist project personnel in completing the required BCRR tables. To aid in setting up data collection systems and in completing Table 5 of the BCRR report, BCHS has issued Primary Care Effectiveness: An Approach to Clinical Quality Assurance in BCHS Programs and Projects, April 1980, and Clinical Data Collection & Retrieval System for a Small Primary Care Setting, April 1979. The Bureau has also issued a Data Analyses Guide to the BCRR, June 1980, to summarize the most common analyses for use by management.

Departmental Federal Assistance Financing System

The Departmental Federal Assistance Financing System (DFAFS) which falls under the auspices of the Federal Assistance Financing Branch (FAFB) of the U.S. Department of Health and Human Services (DHHS), operates as a single payment system and fiscal intermediary between the grantee and the DHHS funding agencies.

The purposes of DFAFS are to:

- serve as most recipients' single point of contact in the department for cash matters;

- provide both the recipient and the department with one standard for continuous and timely reporting of expenditure; and

- facilitate effective cash management.

Health centers must comply with DFAFS recipient reporting requirements. DFAFS Report 27, 27A, 27B, and 27C are the most important reports provided by FAFB. These computer generated reports are furnished to all active recipients at least once per calendar quarter. The pre-printed portion of Part I, Report 27, is mailed to the recipient for completion of expenditure information. Report 27A is mailed to the recipient for reporting of cash and errors which exist in the report.

Contracts, grants, and other awards are normally financed under two principal payment mechanisms:

- Letters of Credit/Single Letter of Credit

- Monthly Cash Request (Via Direct Treasury Checks)

Letter of Credit

The letter of credit is a document which authorizes a recipient to submit payment vouchers (TFS Form #5401) through its commercial bank to a Federal Reserve Bank or branch for deposit of cash in the recipient's commercial bank account. The letter of credit is a commitment certified by an authorized official of DFAFS indicating a dollar amount available to a designated recipient for a specified time -- monthly, quarterly, annually, or without time limit.

A recipient must meet the following requirements to qualify for advance funding by letter of credit from FAFB:

- has, or expects to have, a continuing relationship with the department of at least one year;

- is annually, or expects to be, advanced funds that aggregate at least $120,000 for awards that qualify for financing through DFAFS; or

- has a financial management system that provides for effective control over and accountability for federal funds as required by the Office of Management and Budget (OMB) Circulars A-102 and A-110, as implemented by DHHS through C.F.R. Part 74.

Monthly Cash Request (Direct Treasury Check)

Recipients that are funded through DFAFS, and are not eligible for advancement of funds by DFAFS letter of credit, are financed through DFAFS on a monthly cash request. The recipient must complete a monthly cash request to obtain cash. This payment method is used for the following situations and applies to recipients requiring advance payment to finance their program activities whether by contract, grant, or other agreement:

- o relatively small operations where annual aggregate advance financing is less than $120,000;
- o where the business relationship between the awarding component organization and the recipient is not continuing for at least one year or more;
- o where the cash management objective of letter of credit advance funding is not being achieved; and/or
- o where the recipient's accounting system does not meet the standards for letter of credit financing.

If centers need additional information, they should refer to DFAFS Policy and Procedure Manual for Recipients, April, 1979.

Financial Status Report

The purpose of the Financial Status Report (FSR) Standard Form 269 is to report the status of funds for all non-construction grants awarded for the sources and application of funds. In reference to reporting the FSR, health centers must keep in mind that their reports must be consistent with the accounting system (i.e., accrual or cash). The frequency of reporting FSRs is determined by the grants management awarding officials. Most FSRs are usually done on a monthly, quarterly, or annual basis.

FSRs are due thirty days after the designated reporting period, except when it has been decided that it will be on an annual basis, then they are due ninety days thereafter. The center might require the help of its accounting firm in completing the FSR.

The FSR, when completed correctly, should provide the granting agency and the health center with the following basic information:

- o the balance of funds not yet used or expended;
- o the amount of expenditures already made; and
- o identification of program income.

Medicare

Community health centers are reimbursed under Part B of Title XVIII (Medicare) of the Social Security Act (SSA) which is administered by the Health Care Financing Administration (HCFA). Part B is a voluntary program of supplementary medical insurance whose purpose is to assist qualified Medicare beneficiaries in paying for certain medical services. Medicare Part B requires that the beneficiary meets an annual deductible and pays a 20 percent coinsurance after the deductible is met. Medicare will pay the remaining 80 percent. The beneficiary will pay for noncovered and personal services and noncovered equipment.

In order for centers to receive reimbursement for covered services, they must submit claims in accordance with the instructions set forth by HCFA, which can be obtained from any social security district office or BCHS regional office. Centers may choose to bill through an intermediary or bill directly to HCFA Division of Direct Reimbursement (HCFA/DDR). The first method requires centers to submit a fee-for-services claim, Form 1490, to their local area Medicare carrier. The second method entails dealing directly with HCFA/DDR on a cost related prospective rate, which is determined by HCFA/DDR. Centers billing directly to DDR are required to submit Medicare Cost Reports semi-annually. If health center personnel have problems completing their cost reports, they should not hesitate to contact the regional office for further assistance or engage an accountant experienced in this area.

Medicaid

Medicaid is a federally assisted state program enacted as Title XIX of the SSA. Each state has its own Medicaid program and determines its own benefit and eligibility standards, and the amount of reimbursement for services. States may reimburse health centers, using Medicare's method(s), their own cost based or fixed rate method, or a fee-for-service method.

Rural Health Clinics Act

Under the Rural Health Clinics Act, PL 95-210, both Medicare and Medicaid programs are now involved in improving rural health development and facilitating better reimbursement mechanisms. Through this act, clinics may be reimbursed through Medicare and Medicaid for services not previously covered; that is, services delivered by nurse practitioners and physician assistants.

In regard to Medicare and Medicaid reimbursement, rural health clinics reimbursement is based on an all inclusive rate per visit which represents the average reasonable cost of providing rural health clinic services.

Rural health centers reimbursed under this mechanism also have the responsibility of completing annual cost reports. If assistance is needed, they should refer to the area Medicare intermediary or the regional office.

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ANNOTATED BIOLIOGRAPHY

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Guidelines and Procedures for Cost Finding, Charge Determination and Developing a Sliding Fee Scale in Ambulatory Health Care Centers, 86 pp., 1977. Assists in the development of methods to be used by projects to determine the total unit of cost of services provided. Shows how to use the cost per service information to set charges that will cover costs. Presents a method to adjust charges according to patient's ability to pay. BCHS: Single copy, no charge.

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APPENDIX

APPENDIX

CHECKLIST FOR FINANCIAL MANAGEMENT ANALYSIS

SECTION I: Planning and Budgeting

1. Are short and long-term program goals and measurable objectives established?

2. Are the goals and objectives established in relation to an assessment of past and future needs, evaluation of past performance, and projections of future performance?

3. Is the annual budget prepared relating to the established goals and objectives?

4. Does the program and budget planning process involve the Board, the Executive Director, and Senior Managers?

5. Is the progress toward achievement of goals monitored, the information given to the Board, Executive Director, and Senior Managers, and appropriate action taken periodically?

6. Does the health center have adequate facilities for the kinds of services it provides?

7. Does the health center have a plan for the budgeting process which includes a time schedule?

8. Has the health center provided an adequate system to feedback data in order to refine the planning assumptions?

9. Has the health center identified the budgets necessary and the formats of these budgets?

SECTION II: Fiscal Operations

A. Fee Schedules

1. Does the project follow BCHS policy detailing rate setting procedures?

2. Does the health center have a schedule of charges which it uses for billing third parties and patients?

3. Does the schedule cover all services rendered by the site?

4. Is there a minimum charge regardless of the service rendered or the patient's ability to pay?

5. Are patients refused services because of inability to pay?

6. Is the fee schedule reasonably related to costs?

7. Is the system of discounts based upon the most recent CSA poverty income guidelines?

B. Billing and Collection

1. Does the center have a complete file of registrant information?

2. Are third-party requirements for format and batching followed where appropriate?

3. Does the billing system capture all billable charges and generate bills in a timely manner?

C. Accounts Receivable

1. Are there adequate procedures for handling accounts receivable?

2. Is the collection rate reasonable for the type of project and population served?

3. Are the accounts regularly aged?

4. Are bills and receipts posted daily?

5. Are procedures documented for writing off bad debts?

6. On what basis are accounts written off?

D. Purchasing and Inventory Control

1. Purchases are authorized by:

   - Name;
   - Title;
   - Limit;

2. Does the health center have an adequate inventory control system for:

   - supplies;
   - equipment; and
   - pharmaceuticals.

3. Is the equipment tagged or otherwise marked to identify it as organizational property?

4. What are the dates of the last physical inventory of:

   - supplies;
   - equipment; and
   - pharmaceuticals.

5. Does the same person handle patient receipts and disbursements?

6. Are supplies and equipment paid for only after requisition, packing slip, and bills are received?

SECTION III: Accounting and Internal Control

1. Is the accounting system (including chart of accounts) adequate and appropriate for the size and complexity of the project?

2. Are the financial records adequate to meet operating needs and obligations to patients, governmental or other grantors, and third-party payors?

3. Are specific written procedures established and followed regarding: maintenance of books of account; handling of contributions; personnel and payroll policies; safeguards for handling cash receipts and petty cash; purchase of capital and noncapital items; inventory system; insurance coverage; and accounts payable?

4. Do the latest financial statements indicate the organization is in good fiscal condition?

5. Does the health center have a chart of accounts which describes the way financial data for assets, liabilities, surplus, revenue, and expenses will be displayed?

6. What is the accounting cycle period and how frequently are accounting reports prepared?

7. Are all employees who handle cash, securities, and other valuables bonded?

8. What are the procedures to control cash disbursements?

9. What are the procedures to control cash receipts and deposits?

10. What are the procedures to control payroll?

11. What are the procedures to control accounts receivable?

12. Does the internal control system satisfactorily record and report transactions and safeguard assets?

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